Department of Commerce
WORKERS' COMPENSATION COMMISSION
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
P.O. Box 5795 CHRB, Saipan MP 96950
Tel: (670) 664-8018/8024 • Fax (670) 664-8074
Website: www.commerce.gov.mp

WCC FILE #: _____
CARRIER'S #: _____
EMPLOYER'S #: _____

NOTICE OF EMPLOYEE'S INJURY OR ILLNESS

(To Be Completed By Employee)

INSTRUCTIONS: *This form may be used by the EMPLOYEE to file a NOTICE OF INJURY or ILLNESS, or in the case of death, by the EMPLOYEE'S representative. No benefits need to be paid without this notice. Notice shall be given to the Administrator and to the Employer by delivery or mail to the last known address. This notice is required by 4 CMC 9321.*

THIS IS NOT A CLAIM FOR COMPENSATION

1. Name of injured employee: S.S.N.:	2. Name of Employer: Fed. ID. No.:
3. Employee's Address & Phone No.:	4. Employer's Address
5. Date and Time of Alleged Injury/illness:	6. Did employee stop work? ☐ Yes ☐ No If yes, date stopped:
7. Employee's Occupation:	8. Name of Supervisor at the time of injury:
9. Place where injury occurred:	
10. Is another person (not your fellow employee) the cause of the accident/injury? ☐ Yes ☐ No	11. If you answer "Yes" to item 10, will you file a suit against the other person? ☐ Yes ☐ No

12. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED. (Relate the events which resulted in the injury/illness. Tell what the Employee was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance involved and tell how they were involved. Give full details on factors which led or contributed to the accident.)

(Use additional sheets if necessary and attach to this Notice)

13. Effects of the injury (Indicate parts of body affected and how affected)

14. Employee's Signature	16. Print name of person completing this form:
15. Signature of person completing this Notice:	17. Date of this Notice